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AUTHOR Duffy, Michael
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ABSTRACT

Although the contributions made by counseling psychologists to nursing homes has been marginal, there are several services that can be provided to long-term care facilities by psychologists. Once familiar with the pattern of nursing home life, the psychologist will be able to provide services indirectly as a consultant or trainer, and directly in the delivery of mental health services. As consultants and trainers, psychologists can influence continuing education programs often required of nursing home personnel to include training on mental health needs of nursing home residents. Four workshops developed to provide such education include: (1) Crisis Management in Older Persons; (2) The Family of the Nursing Home Resident: Adversary or Advocate; (3) Using Volunteers in the Nursing Home and Making It Work; and (4) Brief Interventions for Problem Behaviors of Residents. The most frequently requested direct service is for assessment of residents' mental status and treatment recommendations. If diagnostic reports and recommendations are used for care planning, the counseling psychologist can have input into the management of such predictable resident behavior problems as oppositional and noncompliant behavior, depression, agitation and anxiety, social withdrawal, and cognitive disorientation. Although the magnitude of mental health problems in nursing homes and the inadequacy of current services concern counseling psychologists, the problems of adequate and legitimate financial reimbursement must be addressed at a national level if professionals are to be attracted to the field of geriatric mental health in long-term care settings. (NB)

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ROLES FOR THE COUNSELING PSYCHOLOGIST IN THE NURSING HOME

Michael Duffy

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Roles for the Counseling Psychologist in the Nursing Home

Professional psychology has in general been slow to become involved in the emerging field of geriatric mental health, a situation which has been influenced by such issues as the lack of trained professionals and the difficulties of financial reimbursement for services. Specifically, the impact of counseling psychologist has been marginal and certainly lags behind the limited contribution of clinical psychologists. Meanwhile, the need for mental health professionals in long term care is becoming critical and there is a growing urgency in the requests of nursing homes for the services of psychologists. This paper discusses a series of roles and services which can be provided by counseling psychologists-especially those who have an interest in clinical aspects of gerontology. Counseling psychology, with its traditional emphasis on developmental aspects of pathology, fits well with the current emphasis on life-span development within the general field of gerontology.

The first task of the counseling psychologist considering work in long-term geriatric setting is to become familiar with the workings of a nursing home: the type and composition of both staff and residents; the typical range of mental health as well as physical problems; the organization and politics of long term care; the fiscal and reimbursement patterns of health services; and a sensitive understanding of the pressures and problems faced by staff in this very difficult area. There is no shortage of external critics of nursing homes; there is, however, a critical shortage of people (including professionals) willing to work constructively from within the system to improve quality of care.

What follows is not intended to be a comprehensive view of the role of the counseling psychologist in the nursing home but rather

service roles that have been explored successfully by this author. Once familiar with the pattern of nursing home life the psychologist will find two basic service approaches open: the first is the more indirect role of the consultant and trainer, and the second is the delivery of direct mental health services.

In most states licensure and certification regulations require a minimum number of hours of continuing education for administrators, nurses, activity directors, dieticians and sometimes (although less frequently) for nurse's aides. These educational curricula focus heavily on administrative, medical and dietary aspects of care and less heavily on psychosocial and mental health aspects. This provides an opportunity for the counseling psychologist through patient liaison activities, to educate and influence educational programs to include training on the increasing mental health needs of residents. Over the past few years the author has worked with the state nursing home association in developing continuing education programs on a series of topics relevant to geriatric mental health. This not only provides a source of income but allows a wider influence with staff members in nursing homes. These professionals are rarely trained in psychology, but if mental health concepts and techniques are translated into the terms of daily nursing home experience then participants usually find such training both engaging personally and relevant to their work. The emphasis in this training has been on the "handing over" of psychological skills to nursing home personnel for their use in daily patient care. In order to gain impact and convey their relevance, psychological concepts and skills pertinent to geriatric care are often most effectively introduced initially through their meaningfulness in the personal life experience of participants.

Several such workshops have been offered by the author in recent years. In a program on "Crisis Management with Older Persons", participants first explored the concept of crisis and their own lives and approaches to management in nursing home residents - where the precipitants of crisis are at times epidemic. A clarification of the technical meaning of crisis in mental health versus its popular meanings was useful in determining when specific crisis management techniques are appropriate. This workshop inevitably led to a discussion of suicide and "elective death" among the elderly (which may or may not result from a crisis).

Another workshop series (most topics are presented 4-5 times in different locations) focused on the difficult relationship of nursing home and families in, "The Family of the Nursing Home Resident: Adversary or Advocate". Again, the orientation to this session involved participants in an exploration of the dynamics of their own life as family members in order to help them professionally deal with the often puzzling and conflictual behavior of the resident's family. Various experiential/projective techniques such as family drawings helped participants understand personally the resistance and pain so often present in the triadic relationship between nursing home staff, residents and family members. The training and experience of this author in both family therapy and gerontology seemed to add an important component in suggesting solutions in this difficult area of nursing home life.

A workshop entitled, "Using Volunteers in the Nursing Home and Making it Work" grew out of the author's experience of developing and training a group of nursing home volunteers to deliver paraprofessional mental health services in the local area. While

nursing homes often have many volunteers (frequently in excess of 100!) they often serve a symbolic public relations function and are minimally used in the delivery of services. The workshop, using examples of an innovative project, attempted to "turn around" the current pattern of underutilization of volunteers in nursing homes. The workshop also allowed for the research role of the counseling psychologist since data were gathered from the almost 400 participants (over 5 workshops) on their current volunteer organizations and practices. The results, which supported the impression of underutilization, were later published in a nursing home news magazine with statewide distribution.

As a final example of the training/consultative role of the counseling psychologist, a workshop was presented on, "Brief Interventions for Problem Behaviors of Residents". This session, in addition to focusing on formal therapeutic techniques, placed great emphasis on opportunities for staff to intervene "naturalistically" in the nursing home environment. Using Erikson's lifestage model, participants became actively involved in determining the concrete identity, trust, autonomy, intimacy needs, etc, in the lives of residents. This led to a series of naturalistic strategies, generated by the nursing home personnel themselves, designed to meet these needs. Their common sense strategies were both creative and sophisticated in their level of understanding of needs. It was suggested, for example, that the pervasive problem of maintaining trust in an invasive institutional environment, could be helped by a staff and resident norm against "gossip" or open discussion of residents around the nursing home (e.g. nurse's station) and by a clear commitment to keeping promises and agreements.

These training topics and content grew out of the growing experience of the author in providing direct services in individual nursing homes. Indeed, training will be most effective and well-received if it is based on first-hand experiences of nursing home life. As with other professionals, nursing home staff are quick to recognize (and often discount) trainers who are inexperienced - or, at least, do not acknowledge the gaps in their experience. Because the workshop topics grew out of experience, they also clearly form the basis for many of the interventions the counseling psychologist can deliver directly in the nursing home.

In addition to the lack of available mental health manpower and adequate reimbursement procedures, there are other problems in delivery direct mental health services in nursing homes. Nursing homes are primarily medical care oriented and staff are not attuned to the need or potential for psychological therapy. So, while they are beset by increasing behavior problems among residents, they do not automatically seek help from mental health professionals. Rather than "hard-sell" approaches to convincing them of this need, it has been this author's experience that the best method is gradual: a willingness to help with problem-solving and by the demonstration in a few concrete situations of the utility of psychological methods.

The most frequently requested service is to assess mental status and make treatment recommendations - particularly useful in those situations involving uncertainty about the functional or organic character of disorders. The reason for a request for diagnostic help is often the administrative need to determine or reevaluate the level of care upon which hinges the available financial reimbursement. While this may be less than therapeutic in nature, it does provide the

psychologist an entree to assess the overall situation and make recommendations for improved patient care. The frequent misdiagnosis of functional and organic mental disorders in nursing homes leads to poor specificity of preferred treatment approaches and to inappropriate treatment of residents. Situations arise where unreasonable demands are made of residents whose cognitive capacity is clearly impaired. Conversely, patients with functional disorders can be considered untreatable and their capacity for change is left unchallenged. Accurate diagnosis - at least within the current state of the art - is invaluable in sorting out this confusion and giving guidance to staff. Psychogeriatric assessment techniques are generally inadequate and poorly normed but several new instruments are being developed that provide much greater confidence in test results. Neuropsychologists are giving greater attention to developing tests of organic functioning and versions of objective personality tests (such as the MMPI) and projective tests (such as thematic apperception) have been developed for use with geriatric patients. At the level of organic screening devices, there are several mental status questionnaires which, despite their simplicity, offer a great deal in the diagnostic process. Another benefit to psychologists in assessment work is that it is often the only reimburseable service - at least under the Medicare system. Within the nursing home, diagnostic reports and recommendations can form the basis for staff meetings devoted to care planning. This allows the counseling psychologist to have input into the management of a series of predictable behavioral problems of residents including oppositional and noncompliant behavior, depression, agitation and anxiety, social withdrawal and the symptoms of cognitive disorientation. The

immediate value of this kind of assistance is that staff come to better understand and empathize with resident behaviors and avoid inappropriate reactions. The further development of a concrete intervention plan gives the staff a sense of success with the effectiveness their work. In turn they are more likely to trust the help given by the psychologist and call for further assistance. This whole process is slow and often hampered by inadequate time and attention given to treatment planning in the hectic pace of the nursing home. Other difficulties are the frequent turnover of staff and the seriously inadequate training of staff who deliver most patient care (i.e., nurse's aides).

There is a clear if difficult role for counseling psychologist working in long term care. It requires a willingness to spend time in nursing homes and with staff - often initially with little reimbursement. However, the magnitude of mental health problems in nursing homes, the inadequacy of current services and dismal prospects of current public support must attract the professional concern of counseling psychologists. The field of psychogeriatrics is in an infant stage of development and the needs will not go away. The problems of adequate and legitimate financial reimbursement are critical and must be solved at a national health policy level if professionals are to be attracted to the field. It seems imperative that the Division of Counseling Psychology devote serious attention to these issues.